

FEB 18 1947

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSMISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

1324

State File No. _____

Registration District No. 299Primary Registration District No. 1002Registrar's No. 284

1. PLACE OF DEATH:

(a) County Jackson
 (b) City or town Kansas City
 (If outside city or town limits, write "RURAL" and name of township)
 (c) Name of hospital or institution: General Hospital #2
 (If not in hospital or institution, write street number or location)
 (d) Length of stay: In hospital or institution 12-2-40-1-15-41
 In this community 50 years (Specify whether years, months or days)

8. (a) PRINT FULL NAME George Jones

8. (b) If veteran, No name war _____
 8. (c) Social Security No. No

4. Sex Male 5. Color or race Negro
 6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife Unknown
 6. (c) Age of husband or wife if alive — years

7. Birth date of deceased 11 22 1866
 (Month) (Day) (Year)

8. AGE: Years 74 Months 1 Days 24
 If less than one day hr. _____ min. _____

9. Birthplace Glasco Mo.
 (City, town, or county) (State or foreign country)

10. Usual occupation Unemployed

11. Industry or business

MOTHER FATHER
 { 12. Name Unknown
 { 13. Birthplace Unknown
 { 14. Maiden name Unknown
 { 15. Birthplace Unknown
 (City, town, or county) (State or foreign country)

16. (a) Informant's own signature Record Clerk(b) Address Gen. Hosp. #2

17. (a) Burial (b) Date thereof 1-20-1947
 (Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Highland18. (a) Signature of funeral director Wm. J. McCay(b) Address 1513 1st St.

19. (a) Jan 20 1947 (b) M. M. Brown
 (Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Mo. (b) County Jackson
 (c) City or town Kansas City
 (If outside city or town limits, write "RURAL")
 (d) Street No. 1006 E. 17th St.
 (If rural, give location)
 (e) If foreign born, how long in U. S. A? _____ years.

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 1 day 15
 year 41 hour 4 minute P. M.

21. I hereby certify that I attended the deceased from 12-2-
 _____, 1940 to 1-15-
 _____, 1941

that I last saw him alive on 1-15-
 and that death occurred on the date and hour stated above.

Immediate cause of death Hypostatic Pneumonia

Due to Hypertensive Heart Disease

Due to Arteriosclerosis

Other conditions 720
 (Include pregnancy within 3 months of death)

Major findings: _____
 Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____
 (b) Date of occurrence _____
 (c) Where did injury occur? _____
 (City or town) (County) (State)
 (d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? _____ (Specify type of place)
 (e) Means of injury _____

23. Signature P. J. Turner M. D. or other) _____
 Address Gen. Hosp. #2 Date signed 1-16-47

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

L. L. Harris, Jr.
Licensed Embalmer No. 3388

P. O. Address.....

K. C. M. D.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.